Department of Mental Health
Office of Quality Management and Policy
Report on the 2010 Peer Workforce Survey

Introduction

The Department of Mental Health is committed to continuing its transformation of its mental health system into one that is person and family centered, respects consumer choice, and promotes recovery and resiliency for all service recipients. Fundamental to this transformation is the employment of persons with a psychiatric diagnosis who use their experience and skills to promote recovery for the people served in the program for which they work. These staff persons are often referred to as peer workers. The Department continues to work to expand employment of peers by both the Department and its vendors. DMH intends to track the results of its efforts and set meaningful peer workforce goals regarding increasing the size of the peer workforce and the quality of the experience for the peer workers. To do so, it is necessary to begin to establish information regarding the size and nature of the current peer workforce. This report describes the results of a survey DMH conducted in the spring of 2010 that has furthered this aim.

DMH conducted the peer workforce survey both to establish this baseline and to also learn more about the experience of peer workers in the workforce from the perspectives of both the agency and the peer worker. DMH distributed an online survey, utilizing SurveyMonkey™, to all of its vendors. Providers were sent an email with information about the survey and a direct link to the on-line survey. This survey asked providers about the numbers of peer workers employed in their agency, their job functions, and questions related to wages, hours, and job tenure. The survey also asked the providers about their experience with hiring peers, activities conducted by the agencies to prepare for and support a peer workforce, and any barriers they may have encountered. Providers were asked to identify themselves in the survey solely for the purposes of tracking responses.

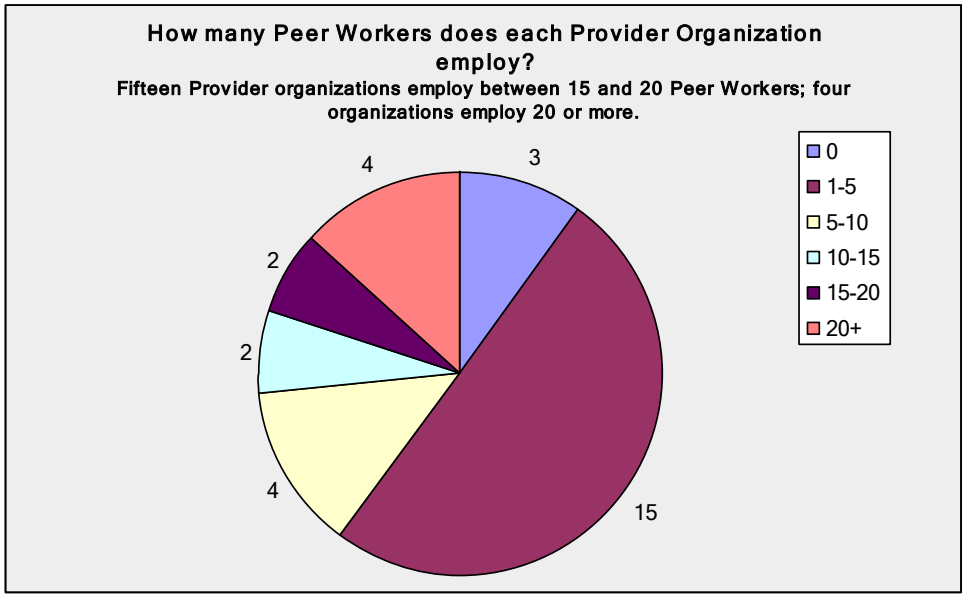
Within the same email, providers were encouraged to distribute information and a direct link to a separate survey to peer workers employed within their agencies. This survey was anonymous; no information about the peer worker or the employing agency was solicited. The survey asked peer workers questions about their employment status, their perceptions of the value of their role in the agency, how they are treated by co-workers, and the supports they may receive. Many of the items in this survey encouraged comments from peer workers and these open ended items proved to be informative in describing the experiences of peer workers.

Provider Agency Survey Results

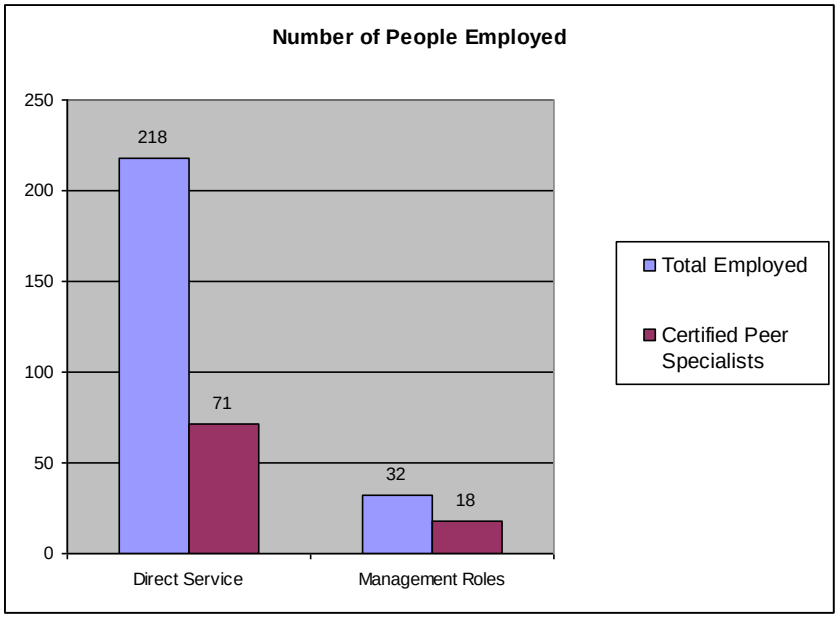
The survey information was provided to 59 contacts, including provider organizations and DMH Area and Central offices. There were 30 responses to the agency survey, representing 20 provider agencies, 3 DMH Area offices and 1 DMH inpatient facility. Thirty five providers and DMH offices did not respond to the survey. Some providers completed more that one response. When multiple responses were completed from the same organization, each response was tabulated individually as the responses appeared to be specific to a division, region or service within the parent organization. However, it is acknowledged that this method may over-represent some agencies. The survey produced a response rate of approximately 41%.

Providers documented a total of 250 people working in peer positions; 218 of these people are providing direct consumer to consumer support services and 32 people are working in

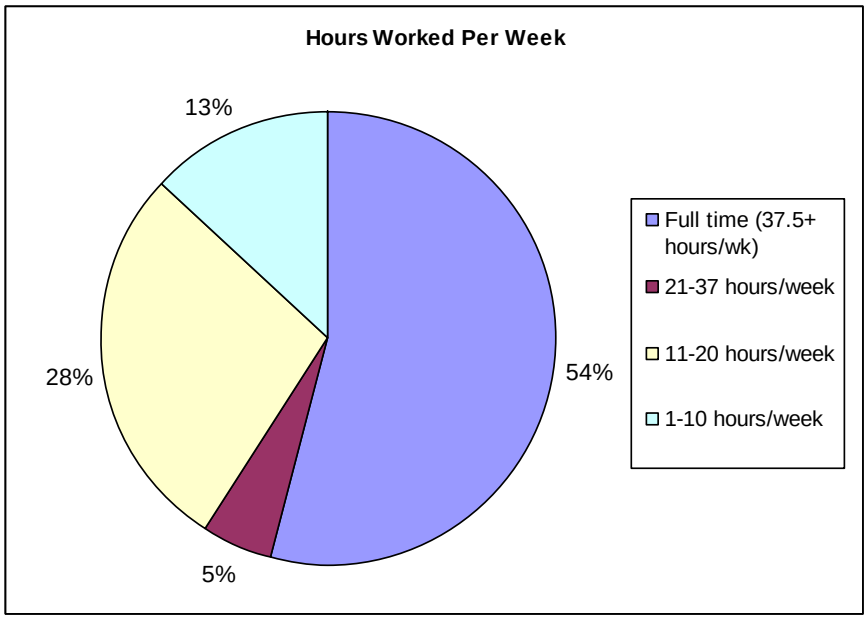
administrative or management positions in which their primary job function related to their lived experience. There is an average of 7 peer workers employed per agency. Three providers reported no peer workers employed in their agency. Four agencies have greater than 20 employed peer workers. There may be some duplication in these numbers as many of these positions are part-time.



Of the218 peers employed in direct service positions, 71 (32%) are Certified Peer Specialists, while 18 of the 32 people (56%) working in administrative or management positions are Certified Peer Specialists.

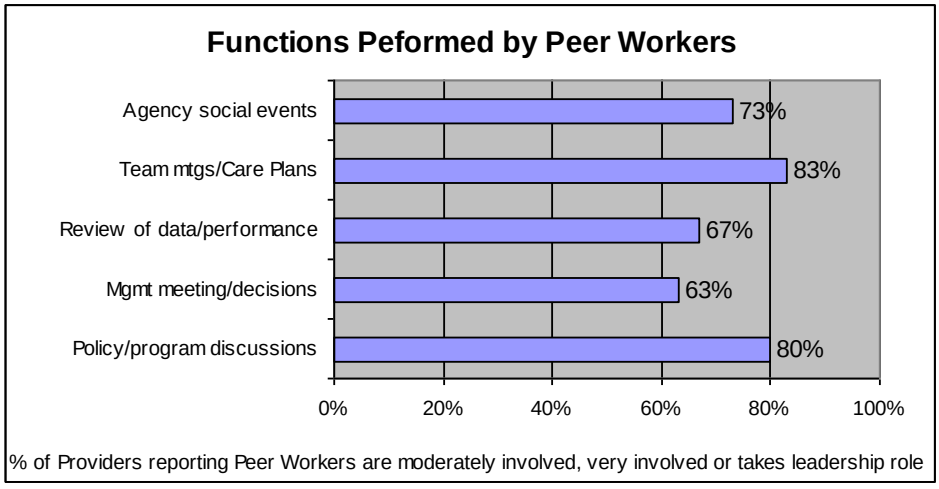


Slightly more than half (54%) of peer workers are employed full-time. Forty one (41%) percent are employed 20 hours or less per week.

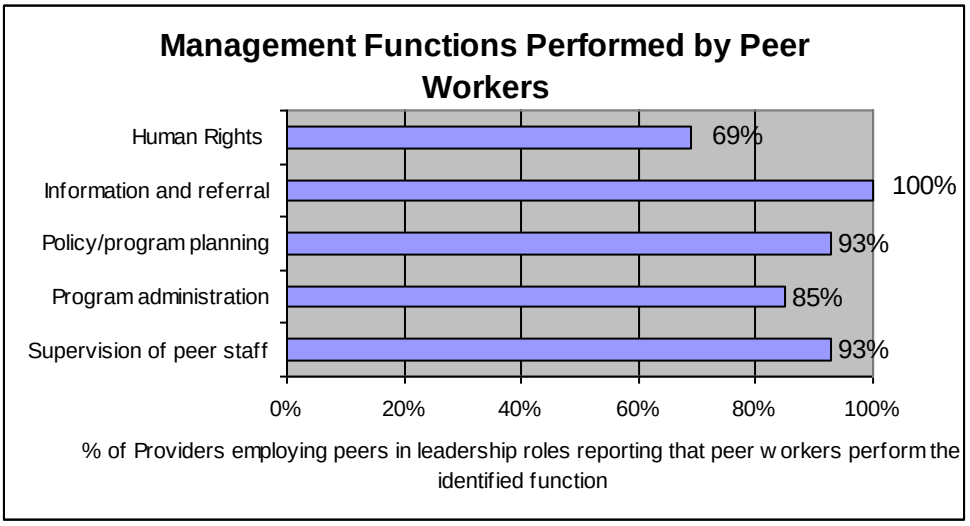


Peer workers' pay ranges from a low of eight dollars per hour to a high of 24 dollars per hour. The most typical pay range is $11-15 per hour, with 33% of providers indicating that hourly wages fell into this category.

Providers report that peer workers assume varied roles and responsibilities within their organizations. Peer workers are most frequently involved in team meetings and care plan development (83%) and policy and program discussions (80%). Peer workers are also involved in management meetings and decisions (63%); review of data and performance (67%); and agency social events (73%). Additional activities in which providers identified that peer workers participate include: responding to Requests for Response (RFRs); special events, such as wellness fairs and art performances; training; and committee work, including review of Representative Payee process, emergency services support, and health and wellness. Providers also report that peer workers are assuming leadership roles in these activities. Nine providers (30%) report that peer workers take a leadership role in policy and program discussions and six (20%) report leadership roles in management meetings and decisions.



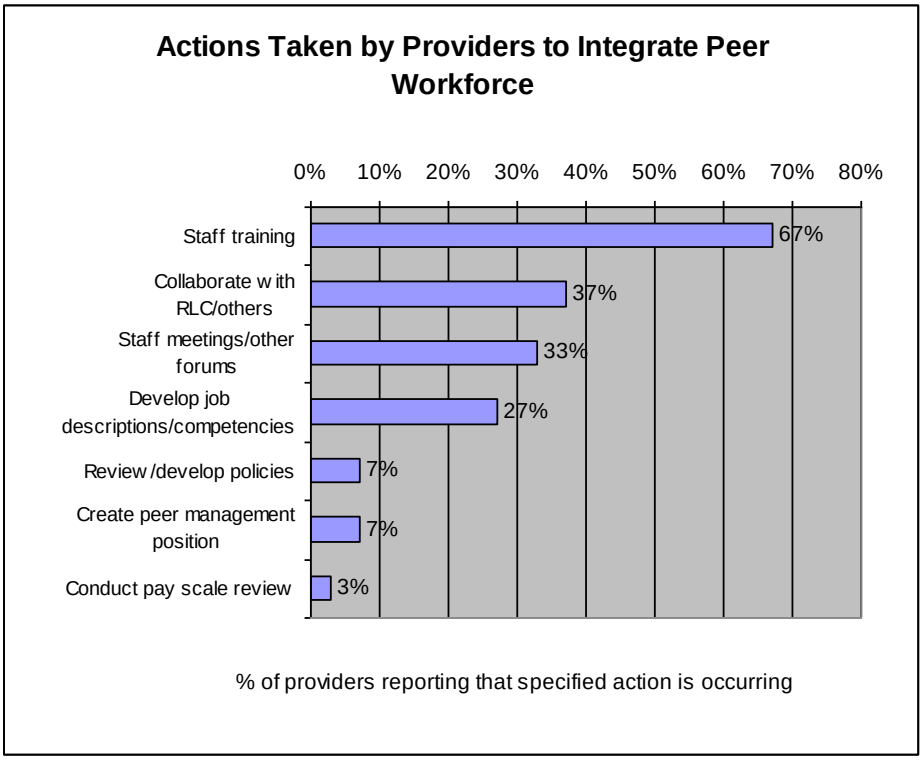
Thirteen providers reported they employed peers in administrative or management positions in which the primary job function relates to the person's experience and expertise about recovery, empowerment and the peer experience. These peers in leadership positions participate in supervision of peer staff; program administration; policy and program planning; information and referral; and human rights.



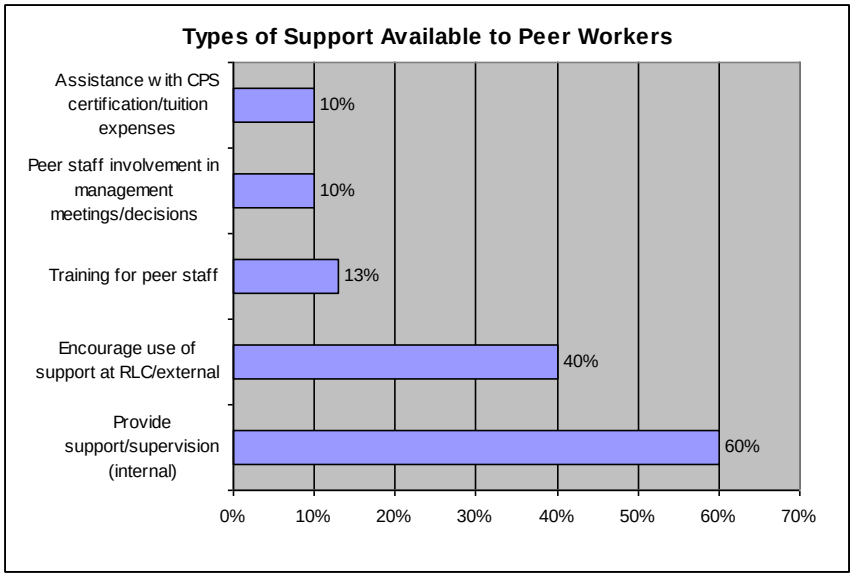
A majority of providers (70%) report that they have plans to expand their peer workforce in the next twelve months, with some providers (five) looking to significantly expand the number of peer worker positions by hiring six or more peer workers. Four providers have no plans to expand their peer workforce in the next year. Other providers are considering expansion depending on contract awards. Providers report plans to create direct care positions in Community Based Flexible Supports (CBFS), Program for Assertive Community Treatment (PACT), Respite, Emergency Service Programs (ESP) and Crisis Stabilization Units (CSU). One provider also reported a plan to hire a management position.
Peer workforce roles are being formalized in a majority of provider organizations. Most providers (90%) have written job descriptions for peer worker positions and a majority of providers (70%) also have a Memorandum of Understanding with their local Recovery Learning Community (RLC). However, less than half (40%) have a policy on utilizing disclosure of a mental health condition to assist clients in a recovery process.

Provider agencies identified a number of actions they are taking to prepare for the integration and support of a peer workforce. The most frequently cited action was training for both peer and non-peer staff. Two thirds (67%) of provider organizations reported that they were conducting training for all staff on the role of peer workers and/or concepts of recovery. Agencies are also utilizing staff meetings and other forums to engage their staff in conversations and share information on topics such as shared decision making, integrating peer workers into specific services, sharing of recovery stories, roles of peer and non-peer staff in the recovery process, and shared values. Some organizations make these discussions open to people served by the agencies and others in the community. Approximately one third (37%) of providers report utilizing the RLCs, Transformation Center, Clubhouses and other organizations in providing training and support on peer workforce integration. Providers also report reviewing and

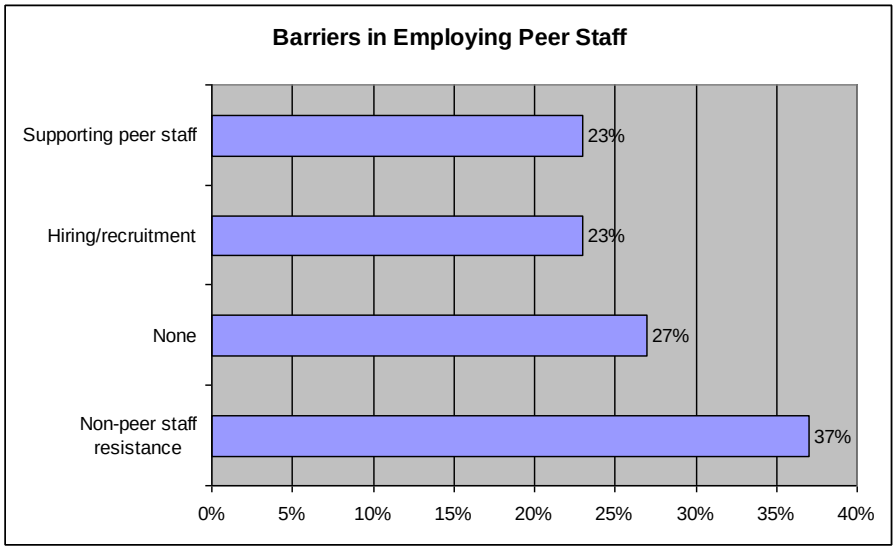
developing policies; developing job descriptions and competencies; creating peer management positions; and conducting a pay scale review and parity study.



Provider organizations also identified opportunities for peer staff to receive support in their innovative roles. The majority of providers (60%) report providing supervision and/or support for peer workers within the agency and 40% report supporting peer workers in utilizing external supports such as statewide peer specialist support meetings, RLC meetings, and linkage to DMH peer workforce initiatives. Several providers reported supporting peer staff involvement in training at regional and national levels offering tuition assistance and support in obtaining CPS certification.



Provider organizations were asked about barriers or issues encountered in the process of employing a peer workforce. While 27% of providers indicated that they have not experienced any barriers, other providers identified multiple challenges. The most frequently cited challenge (by 37% of providers) was resistance from non-peer staff and confusion regarding peer and non-peer roles. Providers reported needing to overcome a culture of a "professionalized" workforce, shift away from the medical model, and address stigma and ambivalence of non-peer staff, including discomfort with expectations of peer staff performance, issues with boundaries and confidentiality, and inclusion of peer staff in care planning meetings. Approximately a quarter of providers (23%) reported issues with the recruitment and hiring process, including a limited workforce of CPSs available for hiring, insufficient pay, lack of transportation, concerns with impact of employment on benefits, and limited opportunity for growth. A quarter of providers (23%) also reported issues supporting peer staff that were experiencing increased symptoms and stress, which at times impacted attendance and performance.



Sixty three (63%) of providers reported some turnover in peer positions. Providers typically identified higher rates of turnover in part-time positions and reported that many of their staff in peer roles, especially full-time roles, have been in the position since it was created. Approximately one third (33%) of providers report that peer staff have left positions for career advancement, including more hours, higher pay, increased responsibilities and to obtain further education. Thirteen percent (13%) of providers also reported peer staff leaving for other positions that were not necessarily an advancement but were a "better fit" with the person's interests, hours, or closer to home. Thirty three percent (33%) reported that peers left positions due to increased stress and symptoms. One provider reported losing peer staff due to layoffs.

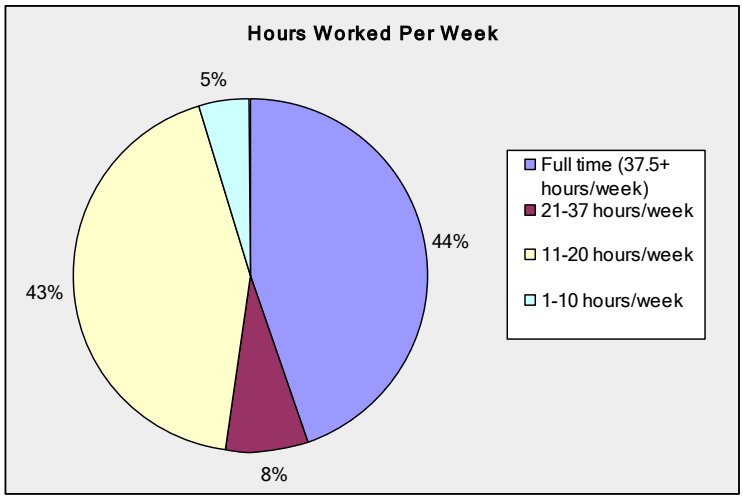
A majority of providers (80%) reported that their organizations would benefit from additional training, support and technical assistance and identified a number of specific needs. These include training and technical assistance in developing policies and procedures, particularly related to human resources; training for non-peer staff on the roles of peer staff and "best practices" of integrating a peer workforce; consultation with other agencies who are doing similar work; technical assistance in creating opportunities to expand the peer workforce;

technical assistance and training in developing the peer worker role; and training in supporting peer workers who are experiencing increased stress.

Peer Worker Survey

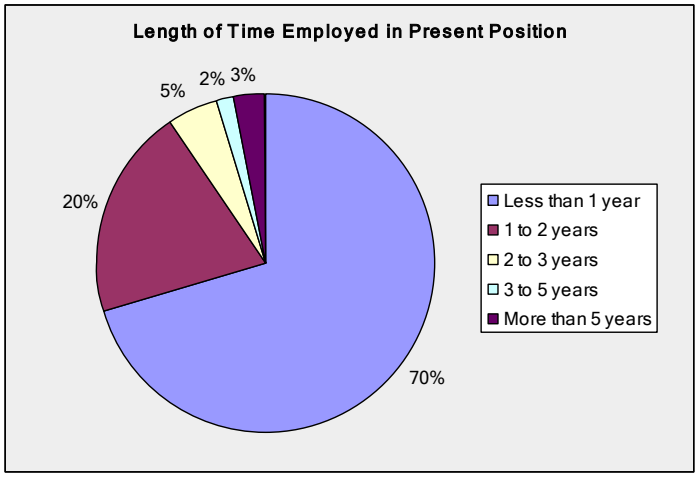
There were 64 responses to the peer worker survey. Since the survey did not identify the person or the agency, it is unknown how many provider agencies distributed the survey to their peer workforce or how many provider organizations are represented in the employee responses.

Of the respondents, 58% are employed as peer workers and 42% as certified peer specialists. Nearly half of these respondents are working full time (45%), while 44% are working 11-20 hours per week.



Over half of peer workers completing the survey reported receiving benefits from their employer (61%). Forty two percent (42%) indicated that their ability to access and pay for health care (including mental health care) has improved since becoming employed. Of those respondents reporting a change in access, 18% reported that their health insurance status improved; 68% reported that their health insurance costs more; and 18% cited other changes, including other financial circumstances affecting their ability to afford health insurance.

The majority (90%) of peer workers report that they have been in their current position for two years or less with 70% of reporting that they have been in their position less than one year. Only one third (31%) of peer workers report that they have held previous peer worker positions.



The 31% of peer workers who had left previous positions offered a number of reasons as to why they had left. The most frequently cited reason (36%) was to gain new experience or skills. A number of these individuals described their departure attributable to their growth as a peer worker/CPS and a desire to "take on a new challenge." Several of these people also cited becoming a CPS and taking on a new position as a result. Twenty three percent (23%) reported leaving their position due to medical or psychiatric illness and an equal number left positions because of budget cuts and lay offs. One person reported leaving their position because of not feeling supported by the employer.

A majority of respondents (89%) reported that they have significant opportunities to utilize their experience about recovery, empowerment and lived experience to benefit the lives of people served by their organization. Of those that provided comments on this item, two thirds (67%) discussed the importance of their recovery story and lived experience as a powerful tool and reported that they are able to utilize these skills effectively in working with people served in their organization.

> *"I find the relationships I have with clients to be very powerful and important for not only the recovery of the client but to staff as well."*

> "*I feel that the organization I work for takes peer support work very serious. I feel I use my experience with recovery everyday"*

> *"I am given much license to use my recovery and develop projects to empower peers on their recovery journey."*

Others expressed frustration that they are asked to perform tasks that are not a part of their peer role, such as general outreach and driving people to appointments and that this leaves little time to *"do more peer work and empower more people with my own experiences."* One person reported that co-workers have been a major obstacle in supporting the peer role, "*Many of my co-workers will not allow me to speak about recovery and sometimes I am constantly in disagreement with one of my co-workers because she has such old ways of dealing with people."* Lastly, several respondents described utilizing lived experience to facilitate change and recovery orientation in their organization by developing trainings and participating in management decisions. *"I have had the opportunity to give my opinion, on how specifically to improve*

current services, present at a conference, give presentations to several organizations, help create a training, and more."

Eighty eight percent (88%) reported that they feel their role is valued within their organization. Of those that provided comments, the majority described positive experiences such as:

> *"My organization is committed to peer work in a real way and really looks towards peers for recovery options and to train non-peers in recovery learning."*

> *"I have received praise and thanks from some people in higher-up positions who I respect, I have been invited to share my knowledge on a RFI and a grant proposal."*

Still others described a mixed experience where they are valued by some, but not all staff in their organization and they face limited awareness of the role and value of peers in their setting.

> *"I feel as though my role is valued in theory but not so much in practice."*

> *"It's valued but still not completely understood. It's new for the agency. But the agency is encouraging and excited."*

> *"Unfortunately, it is only valued by a couple of people and the role itself has not been accepted by the whole workforce."*

One respondent described the challenges of working in a peer role, even when the role is clearly valued.

> *"I am fortunate to work for an organization that has tremendous support for its Peer Specialist Team from Senior Agency Management. This does not mean that we do not face things like stigma in our daily work from other elements of the agency and a less adequate wage that causes stress."*

Another respondent described frustration with the lack of awareness of the peer role and not being able to effectively fulfill this role within the organization.

> *"I often feel that I am a "token peer" and that my position is not valued. I feel that my organization has practically eliminated the peer position and, instead, made peers into outreach workers."*

Peer staff were also asked if they were treated as an equal by co-workers and colleagues and 83% reported that they were. "*We are valued by co-workers and colleagues and treated as equals and consulted on this basis."*

Despite the positive response to this item, many of the comments reflect a more mixed experience with their co-workers. These comments reflect that there are some staff members within their organization that are not aware or accepting of a recovery orientation.

> *"Some of the more 'traditionally' trained employees have difficulty accepting me as an equal-I have been referred to as the 'last resort' for suggestions."*

> *Some coworkers have attitudes that conflict with recovery values. These workers tend to be less endeared by the clients."*

"If supervisor isn't here sometimes regular staff don't listen."

"Sometimes, but I still feel that there needs to be more respect for the peer position, sometimes I am discouraged from helping out, because I would be duplicating services and confusing the person. For example, in certain situations I must ask for permission to help someone with a specific task."

One person described feeling disrespected by co-workers who *"feel that I do nothing all day."*

A majority of peer staff (89%) reported that the culture of their organization promotes recovery and disclosure of having the lived experience of a psychiatric diagnosis. It appears from the comments that some organizations implicitly or explicitly encourage disclosure only for those people in peer roles.

"Yes my organization welcomes peers to disclose how we cope and what we've experienced as long as it benefits someone's wellness."

"Our organization is just starting on the journey of promoting recovery. While the agency embraces and promotes CPS's disclosing lived experience, the same cannot be said of other more traditional providers. There are strict rules on boundaries and disclosure. Disclosure is looked upon as risky and unprofessional for non-cps staff."

Other comments indicate that their organization has taken steps to create an open environment where all staff can disclose lived experience if and when they are ready to do so.

"We have a group that is open to staff with lived psychiatric experience from ALL parts of the agency that meets monthly to discuss how we can create and promote a culture of respect."

"We have a monthly meeting for employees in recovery who have either disclosed or are thinking about it."

"There is tremendous value in traditional providers disclosing lived experience of a psychiatric diagnosis. I am fortunate that I work for an organization that not only allows for its workers to disclose but encourages it."

Approximately half of respondents (47%) report that they are exposed to language or attitudes that are disrespectful or insensitive. A majority of respondents reported (80%) that they point out and discuss the situations with their co-workers. The comments reflect that insensitive language often stems from "old" ways of thinking or language; that pointing this out is a difficult task to do; and that peers need to be supported in doing so.

"Language is an issue, especially with medical staff. Not so much as addressed to me but when staff speak about persons served. Lots of labeling. Lots of negative."

"It is part of the code of ethics for a peer specialist to do so, therefore, I do it whenever the opportunity presents itself."

"It takes great effort but I have been, in the past year, pointing out such occurrences."

"It is inescapable to run into such things, unfortunately--our society and culture have done so for so long, and our agency is cross-disability. However, top leadership at the agency are currently in discussion with peers to try to address how to handle such situations in the most effective yet non-blaming way possible."

Most peer staff (94%) reported that their organization offers or provides access to support specific to their innovative role. Comments frequently cited regular meetings with supervisors and peer worker support groups and that these opportunities exist within their organization as well as through RLCs and the Transformation Center. One respondent described that the organization has a peer worker group but that it is run by a clinician. Several respondents indicated more limited opportunities for supervision and support.

A majority of peer workers (69%) report that they receive reasonable accommodations or other informal flexibility that helps them perform at their best at work. Some of the comments indicated that the person has not needed accommodations but believes the organization would provide them if needed. Most of the comments reflect that organizations are flexible with work hours, including allowing time for appointments, dealing with family emergencies, and work schedules to meet unique needs. Some peer staff also report going to school and that their employers are accommodating of their school schedules. Others reported that their supervisor provides them with support that promotes their performance. One person reported being denied flexibility in work hours to accommodate appointments.

"If I need to leave early for an appointment, I can and make up the time on a later shift."

"I am given some leeway with my position if I am having personal difficulties."

"I am also a full time student, and they are very flexible toward that goal, also if I am having a bad day they are also very flexible toward that as well."

"My mental health is a priority of my supervisor and he checks in with me."

"Was denied a schedule different from my co-workers because it might make others feel I have been given 'special treatment.'"

Discussion

This online survey was conducted in the spring of 2010 by the Department of Mental Health. All provider organizations with a DMH contract were sent emails that described the survey and provided a link to the survey on SurveyMonkey.™ Providers were also encouraged to distribute a separate email and online survey to peer workers employed in their agency. Several reminder emails were sent to provider organizations prior to the end of the survey. The survey produced a response rate of approximately 41%. The response rate for peer workers is not known as this survey was anonymous and DMH does not have information about the number of peer workers who received the survey link and instructions.

This survey method does not allow for the results to be generalized. Since only one third of providers completed the survey, DMH is not able to establish a baseline of the number of peer workers employed. There is also likely to be some duplication in the number of peer workers reported in this survey as many of the positions are part-time and a person may be working for

more than one agency. DMH is not able to determine if there were different characteristics between providers who completed the survey and those that did not. Furthermore, some providers are represented more than once in the survey as they completed separate responses for distinct regions, divisions or services within their organization. Information on characteristics such as size of the organization, number of people served, and services provided were not collected. In addition, DMH did not collect information about the provider's history and experience with promoting recovery orientation or when peer positions were first developed in the agency.

Despite these limitations, the survey results were enlightening and informative. The survey documented that 250 people are employed in peer worker positions. Of those employed, 41% (89 people) are certified peer specialists. According to recent data provided by the Transformation Center, there are currently 267 people who have completed the peer specialist training in Massachusetts and are certified peer specialists. Since approximately two thirds of providers did not respond to the survey, DMH is not able to confirm how many of these CPSs are currently employed or the full extent of the peer workforce. The survey does document that a majority of providers (70%) are looking to continue to expand their peer workforce.

Providers reported that approximately half (54%) of the peer workers are employed half-time while 44% of the peer workers responding to the survey indicated full-time employment. The data from both providers and peer workers indicate the majority of peer workers are either working full-time or less than 20 hours peer week. Very few peer workers (5-8%) are working 21-37 hours peer week. The survey did not seek information on the reasons why positions are either full- or part-time. There may be several contributing factors, including providers creating part-time positions as they beginning to develop peer roles within their organizations as well as some peer workers who may continue to receive public assistance and need to maintain hours and wages below certain thresholds. The development of a peer workforce appears to have some positive impact on peer workers' access to benefits as 61% of peer workers report receiving employer benefits and 42% report their ability to access and pay for health care has improved since becoming employed. The pay range for peer workers is variable with peer workers earning between eight and 24 dollars per hours and a third of providers reported a salary range of $11-15 per hour.

The survey illustrated that the peer workforce is a relatively new one. Most peer workers (90%) reported being in their position less than two years and only one third (31%) have held previous peer worker positions. Two thirds of providers (63%) reported turnover in peer positions, most commonly in part-time positions. There were several positive findings related to job tenure and turnover. First, providers reported that some of their peer staff, often those in full-time positions, have been in their roles since they were created. Based on responses from providers and peer workers about the roles peer staff play in supervision, training, policy decisions and program development, these peer workers appear to be pivotal in promoting practice and culture shifts within their organizations. Second, providers are offering accommodations, flexibility, and support so that peer workers can take care of themselves and their families. Third, providers and peer workers often leave their roles for good reasons such as career advancement, opportunities to gain new experience or skills, and educational pursuits. Lastly, it appears widely accepted among providers and peer workers that opportunities for support and supervision are valued. Nearly all peer workers (94%) reported that their organization provided support, both within and

outside of the agency. A majority of organizations (60%) directly provide supervision/support and 40% reported encouraging peer workers to utilize supports outside of the organization.

Peer workers and CPSs are employed in both direct service and management positions. Over half (56%) of the peers employed in management positions are Certified Peer Specialists. Peer staff are engaged in a variety of direct service roles within provider organizations and are most frequently participating in team meetings and care plan development and policy and program discussions. Most peer workers in management roles are participating in information and referral, program administration, and supervision of peer staff. Nearly all providers (90%) have formal job descriptions for peer positions.

These findings appear to indicate that providers who responded to the survey are integrating peer roles throughout their organizations and are considering the unique skills and strengths that peers bring to their roles in both direct service and management functions. The feedback from peer workers supports this, in that the majority of respondents (89%) indicate that they have significant opportunity to utilize their experience for the benefit of people served. There was evidence through the responses that this opportunity exists both within the relationships they build with the people they serve as well as within the organization as they utilize their experience to inform policy, improve services, and provide training. Some respondents did express frustration that they are asked to perform tasks that are not a part of the peer role and there were some comments that indicated that their role was not fully understood by co-workers or managers.

One of the strongest themes identified by both providers and peer workers was the need for training, particularly for non-peer staff. Over two thirds of providers reported providing training for all staff on peer roles and recovery. Providers also cited non-peer staff resistance as the barrier they most frequently encountered. They described that some of their staff remain embedded in the medical model and that they are challenged by the culture of a "professionalized" workforce that is at times resistant to recovery-based values and practices. Providers identified the importance of utilizing formal trainings and meetings, as well as informal conversations to educate non-peer staff about recovery and peer roles; provide opportunities to share and hear recovery stories, and discuss shared values. Peer workers discussed the roles they are playing in developing and leading these training experiences. They describe opportunities for peer and non-peer staff to openly discuss their lived experience and identify common values.

Peer worker comments also support the importance of addressing the organizational culture and describe the key role of management in creating a workplace that is open to peer staff and roles. They illustrate that the process of becoming a recovery-based organization is a continually evolving and complex process. Peer workers frequently described feeling accepted and valued most of the time and by a majority of their co-workers and managers. However, most also describe situations with individual co-workers or in specific circumstances where their role is not valued or understood or where they are not treated as an equal. They also describe situations in which co-workers are using insensitive or disrespectful language. Peer workers often view these situations as part of larger issues with stigma and "old ways of thinking." Peer workers identified that leadership in their organization must take active roles in promoting this culture shift and supporting peers through this process.

Conclusion

The development of a peer workforce has a long history in Massachusetts. This survey demonstrates that the work of many organizations and individuals is resulting in a strong and vibrant peer workforce that is providing a unique and essential service and is transforming the mental health system into one that is embracing and supporting recovery-based values. Throughout the survey responses, there was evidence of provider organizations taking positive steps toward hiring, integrating, and supporting a peer workforce and of peer workers that are daily using their experience to empower the people they serve and to produce positive changes in their organizations.

At the same time, some peer workers continue to feel isolated, unsupported and undervalued in their roles and nearly half of peer workers identify some situations in which they are confronted with insensitive or disrespectful interactions. The voice of the peer worker was powerful in expressing the successes and challenges that they face and their words were frequently used in the report. It is evident from this small sample that providers are at different points in the process of defining, hiring and integrating a peer workforce and some appear to be experiencing more success than others. Training of non-peer staff and addressing organizational culture when it conflicts with fully embracing a peer workforce were among the strongest themes in the survey results and there is significant opportunity to work with providers and peer workers on this ongoing need. In addition, these ongoing challenges further confirm the need for ongoing support of the peer workforce. Most providers identified an interest in additional training, support, and technical assistance, highlighting both the need and opportunity for improvement.

While this survey process did not provide information regarding the total numbers of peers across the entire DMH and contractor workforce, it has provided significant insights into the areas that DMH can focus on to support and promote the use of peers in the workforce. DMH will determine a process for obtaining a calculation of the total peer workforce to inform goal setting about expansion. DMH will closely examine the findings from this survey, and with its partners determine additional goals and strategies for improving the effectiveness of the peer workforce as it expands.